

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ind.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANKLIN WHITEFIELD COLEMAN</u>		4. DATE OF DEATH <u>Sept. 21 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5-1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES WESLEY COLEMAN</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Temperance Apsley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Reba Coleman</u>		Address <u>Chester Ind.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>Sep-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>sep 19</u> , 19 <u>57</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W Chan E Jude</u> M.D.		ADDRESS (Street, city or town, state) <u>Stevensville Md.</u> DATE SIGNED <u>9/23/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 24</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar R. Kane</u>		24a. REC'D BY REGISTRAR <u>SEP 26 1957</u>	
ADDRESS <u>Church Hill, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>E. L. A. Hoxter</u>	

BUREAU V. S.

SEP 26 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9858 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09853

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Del</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crumpton P 70</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wyoming</u> 46X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Lyndon O. Cough</u>				4. DATE OF DEATH <u>Sept 17</u> 19 <u>57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 1-1885</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robt Kent Cough</u>				14. MOTHER'S MAIDEN NAME <u>Annie L. Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>222-05-518</u>		17. INFORMANT <u>Miss Beulah Jordan</u> Address <u>WYOMING, DEL RD #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto accident - Fractured skull.</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>2:15</u> a. m. <u>9-17</u> 19 <u>57</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State Highway</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/18-57</u>	
EXAMINER'S NAME (Type) <u>Quintessence mde</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Yellowlam.</u>		22d. LOCATION (City, town, or county) (State) <u>Camden Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Yellowlam</u>				ADDRESS <u>Millington Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 23 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edgar Loper</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

NAME OF DECEASED: *James H. Jones*  
 SEX: *Male* AGE: *67-188*  
 DATE OF DEATH: *Sept 23 1967*  
 PLACE OF DEATH: *Home*  
 CAUSE OF DEATH: *Heart Disease*  
 MANNER OF DEATH: *Natural*  
 SIGNATURE OF EXAMINER: *James H. Jones*  
 DATE: *Sept 23 1967*

BUREAU V. 3

SEP 23 1967

RECEIVED

9857

CERTIFICATE OF DEATH

09854

Reg. Dist. No. 283

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS —			
3. NAME OF DECEASED (Type or print) First <u>Olive</u> Middle <u>Luttrell</u> Last <u>Eaton</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1911</u>		9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin Luttrell</u>				14. MOTHER'S MAIDEN NAME <u>Priscilla Shoney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-18-5034</u>		17. INFORMANT <u>Gardner Eaton</u>		Address <u>Chester, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Of the Breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1</u> , 19 <u>57</u> to <u>Sept. 11</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Sept. 11</u> , 19 <u>57</u> , and that death occurred at <u>11 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u>				ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u>		DATE SIGNED <u>9/11/57</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 14</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Kane</u>				ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 16 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Hester</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1910</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. RACE <i>White</i>		7. OCCUPATION <i>Teacher</i>		8. MARITAL STATUS <i>Married</i>		9. DATE OF DEATH <i>Sept 10 1957</i>		10. PLACE OF DEATH <i>Home</i>		11. CAUSE OF DEATH <i>Heart Disease</i>		12. MANNER OF DEATH <i>Natural</i>		13. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. SIGNATURE OF REGISTRAR <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1910</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. RACE <i>White</i>		7. OCCUPATION <i>Teacher</i>		8. MARITAL STATUS <i>Married</i>		9. DATE OF DEATH <i>Sept 10 1957</i>		10. PLACE OF DEATH <i>Home</i>		11. CAUSE OF DEATH <i>Heart Disease</i>		12. MANNER OF DEATH <i>Natural</i>		13. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. SIGNATURE OF REGISTRAR <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. E.  
SEP 16 1957

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR THE PURPOSES OF THE FEDERAL BUREAU OF INVESTIGATION.

9858

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CRUMPTON</u>		c. LENGTH OF STAY IN 1b <u>CRUMPTON RURAL</u> X1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>William</u> First <u>H.</u> Middle <u>H.</u> Last <u>HAZELL</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1881</u> 75 yrs.
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>GEORGE THOMAS HAZELL</u>		14. MOTHER'S MAIDEN NAME <u>ALICE HAZELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>GEORGE HAZELL</u>	
		17. INFORMANT <u>CRUMPTON MD.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cachexia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1956</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Asthenia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tw</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 17, 1957 to Sept 5, 1957 that I last saw the deceased alive on Sept 4, 1957, and that death occurred at 9:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE <u>C. H. METCALFE</u>	M.D. <u>Sept 4, 1957</u>	ADDRESS (Street, city or town, state) <u>CRUMPTON MD.</u>	DATE SIGNED <u>9/6/57</u>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CHESTER CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>CRISTERTOWN MD.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>	24a. REC'D BY REGISTRAR <u>SEP 9 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH 12-5-21	
5. PLACE OF BIRTH MOBILE, ALABAMA		6. OCCUPATION None	
7. MARITAL STATUS Single		8. EDUCATION High School	
9. RELIGION None		10. RACE White	
11. DATE OF DEATH 4-4-68		12. TIME OF DEATH 11:00 AM	
13. PLACE OF DEATH FBI Building, Memphis, TN		14. CAUSE OF DEATH Suicide	
15. MANNER OF DEATH Suicide		16. SIGNATURE OF DECEASED None	
17. SIGNATURE OF WITNESS None		18. SIGNATURE OF PHYSICIAN None	
19. SIGNATURE OF CORONER None		20. SIGNATURE OF JUDGE None	
21. SIGNATURE OF CLERK None		22. SIGNATURE OF REGISTRAR None	
23. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		24. SIGNATURE OF DECEASED'S NEXT OF KIN None	
25. SIGNATURE OF DECEASED'S MOTHER None		26. SIGNATURE OF DECEASED'S FATHER None	
27. SIGNATURE OF DECEASED'S SISTER None		28. SIGNATURE OF DECEASED'S BROTHER None	
29. SIGNATURE OF DECEASED'S UNCLE None		30. SIGNATURE OF DECEASED'S AUNT None	
31. SIGNATURE OF DECEASED'S GRANDFATHER None		32. SIGNATURE OF DECEASED'S GRANDMOTHER None	
33. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		34. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
35. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		36. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
37. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		38. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
39. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		40. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
41. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		42. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
43. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		44. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
45. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		46. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
47. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		48. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
49. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		50. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
51. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		52. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
53. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		54. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
55. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		56. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
57. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		58. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
59. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		60. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
61. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		62. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
63. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		64. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
65. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		66. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
67. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		68. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
69. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		70. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
71. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		72. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
73. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		74. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
75. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		76. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
77. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		78. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
79. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		80. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
81. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		82. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
83. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		84. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
85. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		86. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
87. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		88. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
89. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		90. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
91. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		92. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
93. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		94. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
95. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		96. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
97. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		98. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	
99. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER None		100. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER None	

BUREAU V. 3

SEP 9 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9859

09856

CERTIFICATE OF DEATH

Item 14, Film G221, 10/3/57 for

Reg. Dist. No.

257

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>X2 Centreville</u>			
3. NAME OF DECEASED (Type or print) <u>Margaret</u> First <u>R.</u> Middle <u>Hollingsworth</u> Last				4. DATE OF DEATH Month <u>Sept.</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 28-1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Samuel Moore</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Miss Mildred Hollingsworth--Centreville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> (c) <u>Atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>33</u> , to <u>Sept 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 14</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.F. McPherson</u> M.D.				ADDRESS (Street, city or town, state) <u>Centreville</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>H.F. McPherson</u>				<u>Centreville</u> Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Sept. 17</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Centreville</u>		22d. LOCATION (City, town, or county) (State) <u>Centreville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Kane</u>				ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 23 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Thelma Strong</u>			

CERTIFICATE OF DEATH

1. Name of Deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of Birth: *Jan 15 1912*

5. Date of Death: *Sept 20 1957*

6. Place of Death: *Home*

7. Cause of Death: *Heart Disease*

8. Physician: *Dr. J. Smith*

9. Burial Place: *Catholic Cemetery*

10. Signature of Physician: *[Signature]*

11. Signature of Registrar: *[Signature]*

12. Date of Registration: *Sept 23 1957*

BUREAU V. S.

SEP 23 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09857 254  
Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Queen Anne</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McGuinnis Corner</u>			c. LENGTH OF STAY IN 1b  		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Chestertown RT 7041</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS  		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>John Franklin Lipscomb</u>				<b>4. DATE OF DEATH</b> Month <u>Sept</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29-1944</u>	
9. AGE (In years last birthday) <u>13</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School boy</u>				10b. KIND OF BUSINESS OR INDUSTRY  		11. BIRTHPLACE (State or foreign country) <u>MD =</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Clarence Lipscomb</u>				14. MOTHER'S MAIDEN NAME <u>Betty Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs Betty Hilder</u> Address <u>Chestertown RT 7041</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto + bicycle in collision - boy killed</u> <u>813X</u> DUE TO <u>with broken neck &amp; broken right arm.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>20 9-17-1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State road</u>		20f. (City or town) <u>McGuinnis - Queen Anne</u> (County) <u>MD</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. Henry Foster</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Centerville MD -</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9/18-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL</u>		22d. LOCATION (City, town, or county) (State) <u>CHURCH HILL MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Foster</u>				ADDRESS <u>CHURCH HILL</u>		24a. REC'D BY REGISTRAR DATE <u>9/23/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Edgar L. Foster</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for and to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 24 1957

BUREAU V. S.

9861

## CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sussex</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>TILLIE MARSHALL PRATT</u>		4. DATE OF DEATH Month Day Year <u>Sept 14 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 22-1869</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Queen Anne's Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Charles County Co. Centerville Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dehydration</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Syncope</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral Hemorrhage 1950 Fracture neck of femur 1951</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>20</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>17</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1954</u> to <u>Sept 14, 1957</u> , that I last saw the deceased alive on <u>Sept 14, 1957</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. White</u> M.D.		DATE SIGNED <u>Sept 17, 1957</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 17-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. White</u>		24a. REC'D BY REGISTRAR DATE <u>9/17</u>	
ADDRESS <u>Centerville Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Kane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU W. I.

SEP 04 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
Item 20b Film 220 9-20-57 and Item 9 Film 220 9-19-57 et														
9862														
Reg. Dist. No. 09859 253														
1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Queen Anne</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>					c. LENGTH OF STAY IN 1b <u>x 2</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Agnes</u> Last <u>Roe</u>					4. DATE OF DEATH Month <u>Sept</u> Day <u>9</u> Year <u>1957</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 26-1908</u>		9. AGE (In years last birthday) <u>48 49</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Walmart</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Water</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME <u>John C. Roe</u>					14. MOTHER'S MAIDEN NAME <u>Mary C. Hesse</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO.					17. INFORMANT <u>Agnes Roe (Sister)</u> Address <u>Stevensville Md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burned to death</u> DUE TO <u>House caught fire + burned + he burned</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>to death</u> (c) <u>to death</u>										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Don't know how house caught fire - but it was thought from cigarette lighting to lounge</u>														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Don't know how house caught fire - but it was thought from cigarette lighting to lounge</u>										
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12</u> p. m. <u>9-9-57</u> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sisters home</u>		20f. (City or town) <u>nr. Stevensville QA</u>		(County) (State) <u>Md.</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>Sept. 12</u>			22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar R. Lane</u>						24a. REC'D BY REGISTRAR <u>Chubb Hill</u>			24b. REGISTRAR'S SIGNATURE <u>Ely B. Taylor</u>					
25. ACTUAL SIGNATURE <u>W. Henry Fisher</u>						26. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>9/11-57</u>					
27. EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u>						28. ASSISTANT MEDICAL-EXAMINER <input type="checkbox"/>			29. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					

SEP 16 1957

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED *Stevenson*  
 RESIDENCE *Stevenson*  
 DATE OF DEATH *Sept 16 1957*  
 PLACE OF DEATH *Stevenson*

CAUSE OF DEATH *John*  
 MANNER OF DEATH *John*  
 AGENT *John*  
 DATE OF EXAMINATION *Sept 16 1957*

PLACE OF EXAMINATION *John*  
 NAME OF PHYSICIAN *John*  
 NAME OF PATHOLOGIST *John*  
 NAME OF ANATOMIST *John*

NAME OF CORONER *John*  
 NAME OF JURY *John*  
 NAME OF JURY *John*  
 NAME OF JURY *John*

NAME OF JURY *John*  
 NAME OF JURY *John*  
 NAME OF JURY *John*  
 NAME OF JURY *John*

NAME OF JURY *John*  
 NAME OF JURY *John*  
 NAME OF JURY *John*  
 NAME OF JURY *John*

**RECEIVED**  
 SEP 16 1957  
 BUREAU V. 3

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9863

## CERTIFICATE OF DEATH

Reg. Dist. No. 098681

1. PLACE OF DEATH o. COUNTY <b>Queen Anne</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bridgetown Rural</b>				c. LENGTH OF STAY IN 1b <b>10 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>				d. STREET ADDRESS <b>None</b>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>B.</b> Last <b>Weaver</b>				4. DATE OF DEATH Month <b>9</b> Day <b>20</b> Year <b>57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/20/1884</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Benedict Weaver</b>				14. MOTHER'S MAIDEN NAME <b>Mary Kitchline</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Wilson Weaver Henderson, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Embolism</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Small Arteries</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>4:00</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>April 1957</b> , to <b>Sept 20, 1957</b> that I last saw the deceased alive on <b>Sept 19, 1957</b> , and that death occurred at <b>2:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. White</b> M.D.				DATE SIGNED <b>9/20/57</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMAINS (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>9/22/57</b>		<b>Ridgely</b>		<b>Ridgely, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. E. Boula's Greensboro, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>9/22</b>		24b. REGISTRAR'S SIGNATURE <b>Edgar L. Lane</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Robert	
Sex		Male	
Date of Birth		1910	
Place of Birth		Maryland	
Date of Death		September 26, 1957	
Place of Death		Home	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Signature of Informant		[Signature]	
Address of Informant		[Address]	
City		Baltimore	
State		Maryland	
County		Baltimore	
Zip		21201	

*Handwritten notes:*  
 Cause of Death: Heart Disease  
 Manner of Death: Natural  
 Signature of Physician: [Signature]  
 Signature of Registrar: [Signature]  
 Signature of Informant: [Signature]  
 Address of Informant: [Address]  
 City: Baltimore  
 State: Maryland  
 County: Baltimore  
 Zip: 21201

BUREAU V. 2

SEP 26 1957

RECEIVED

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## CERTIFICATE OF DEATH

Reg. Dist. No.

09861 251

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - SUPLERSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - SUPLERSVILLE</u>			
c. LENGTH OF STAY IN 1b <u>40 YRS.</u>				d. STREET ADDRESS <u>R.D.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE BENJAMIN WELCH</u>				4. DATE OF DEATH Month Day Year <u>SEPTEMBER 27 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 4, 1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE FRANKLIN WELCH</u>			
14. MOTHER'S MAIDEN NAME <u>DELLA RENA BRISCOE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>			
16. SOCIAL SECURITY NO. <u>220-34-9843</u>				17. INFORMANT Address <u>MRS. KATHERINE B. WELCH, SUPLERSVILLE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arterial Sclerosis</u> DUE TO (c) <u>Coronary Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage 5 yrs ago</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>W</u>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>W 19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Oct 1949</u> , to <u>Sept 27 1957</u> , that I last saw the deceased alive on <u>Sept 25 1957</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. J. White</u> M.D.				ADDRESS (Street, city or town, state) <u>Suplersville, Md.</u> DATE SIGNED <u>Oct 14/1957</u>			
PHYSICIAN'S NAME (Type) <u>C. J. White</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SUPLERSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>SUPLERSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar J. Langston</u> ADDRESS <u>CHURCH HILL, MD</u>				24a. REC'D BY REGISTRAR DATE <u>10/1</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar R. Dane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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